Madison Dental Care
Patient Information (please print)

Date: _____

Name: _____
First Mi Last

Address: _____ City: _____ State: ___ Zip: ____

Birthdate: _____ Email: _____

SS#: _____ Cell Ph: _____ Home Ph: _____

Circle: Minor Single Married Divorced Widowed Separated

Whom May We Thank for Referring You? _____

Person to Contact in Case of an Emergency: _____

Emergency Contact Phone: _____

<u>Responsible Party</u>

Name of Person Responsible for This Account: _____

Relationship to Patient: _____

Address: _____ Home Ph: _____

Birthdate: _____ Employer: _____ Work #: _____

Is This Person Currently a Patient In Our Office: Yes No

Insurance Information

Name of Insured: _____

Relationship to Patient: _____ Birthdate: _____

SS#: _____

Name of Employer: _____ Work Ph: _____

Address of Employer: _____ City: _____

State: _____ Zip: _____ Insurance Company: _____

Group #: _____ Ins. Co. Address: _____

City: _____ State: _____ Zip: _____ Contract #: _____

Do You Have Additional Insurance?: Yes No

If Yes, complete the following:

Name of Insured: _____

Relationship to Patient: _____

Birthdate: _____ SS#: _____ Date Employed: _____

Name of Employer: _____ Work #: _____

Address of Employer: _____ City: _____

State: _____ Zip: _____ Contract #: _____

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) **Yes No DK**

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date Treatment began: _____

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink i n a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Yes No DK

Local anesthetics _____ ☐ ☐ ☐
Aspirin _____ ☐ ☐ ☐
Penicillin or other antibiotics _____ ☐ ☐ ☐
Barbiturates, sedatives, or sleeping pills _____ ☐ ☐ ☐
Sulfa drugs _____ ☐ ☐ ☐
Codeine or other narcotics _____ ☐ ☐ ☐

Yes No DK

Metals _____ ☐ ☐ ☐
Latex (rubber) _____ ☐ ☐ ☐
Iodine _____ ☐ ☐ ☐
Hay fever/seasonal _____ ☐ ☐ ☐
Animals _____ ☐ ☐ ☐
Food _____ ☐ ☐ ☐
Other _____ ☐ ☐ ☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes No DK

Artificial (prosthetic) heart valve ☐ ☐ ☐
Previous infective endocarditis ☐ ☐ ☐
Damaged valves in transplanted heart ☐ ☐ ☐
Congenital heart disease (CHD)
- Unrepaired, cyanotic CHD ☐ ☐ ☐
- Repaired (completely) in last 6 months ☐ ☐ ☐
- Repaired CHD with residual defects ☐ ☐ ☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes No DK

Cardiovascular disease ☐ ☐ ☐
Angina ☐ ☐ ☐
Arteriosclerosis ☐ ☐ ☐
Congestive heart failure ☐ ☐ ☐
Damaged heart valves ☐ ☐ ☐
Heart attack ☐ ☐ ☐
Heart murmur ☐ ☐ ☐
Low blood pressure ☐ ☐ ☐
High blood pressure ☐ ☐ ☐
Other congenital heart defects ☐ ☐ ☐

Yes No DK

Mitral valve prolapse ☐ ☐ ☐
Pacemaker ☐ ☐ ☐
Rheumatic fever ☐ ☐ ☐
Rheumatic heart disease ☐ ☐ ☐
Abnormal bleeding ☐ ☐ ☐
Anemia ☐ ☐ ☐
Blood transfusion ☐ ☐ ☐
If yes, date: _____
Hemophilia ☐ ☐ ☐
AIDS or HIV infection ☐ ☐ ☐
Arthritis ☐ ☐ ☐

Yes No DK

Autoimmune disease ☐ ☐ ☐
Rheumatoid arthritis ☐ ☐ ☐
Systemic lupus erythematosus ☐ ☐ ☐
Asthma ☐ ☐ ☐
Bronchitis ☐ ☐ ☐
Emphysema ☐ ☐ ☐
Sinus trouble ☐ ☐ ☐
Tuberculosis ☐ ☐ ☐
Cancer/Chemotherapy/ Radiation Treatment ☐ ☐ ☐
Chest pain upon exertion ☐ ☐ ☐
Chronic pain ☐ ☐ ☐
Diabetes Type I or II ☐ ☐ ☐
Eating disorder ☐ ☐ ☐
Malnutrition ☐ ☐ ☐
Gastrointestinal disease ☐ ☐ ☐
G.E. Reflux/persistent heartburn ☐ ☐ ☐
Ulcers ☐ ☐ ☐
Thyroid problems ☐ ☐ ☐
Stroke ☐ ☐ ☐

Yes No DK

Glaucoma ☐ ☐ ☐
Hepatitis, jaundice or liver disease ☐ ☐ ☐
Epilepsy ☐ ☐ ☐
Fainting spells or seizures ☐ ☐ ☐
Neurological disorders ☐ ☐ ☐
If yes, specify: _____
Sleep disorder ☐ ☐ ☐
Do you snore? ☐ ☐ ☐
Mental health disorders ☐ ☐ ☐
Specify: _____
Recurrent Infections ☐ ☐ ☐
Type of infection: _____
Kidney problems ☐ ☐ ☐
Night sweats ☐ ☐ ☐
Osteoporosis ☐ ☐ ☐
Persistent swollen glands in neck ☐ ☐ ☐
Severe headaches/ migraines ☐ ☐ ☐
Severe or rapid weight loss ☐ ☐ ☐
Sexually transmitted disease ☐ ☐ ☐
Excessive urination ☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Additional Person Authorization

Purpose: To ensure authorization that releases Madison Dental Care to speak with additional persons regarding patient care.

I, _____, patient of Madison Dental Care, authorize the following individuals to be able to discuss my care and/ or appointments at Madison Dental Care with my attending physician and clinical staff, as well as any insurance or billing issues.

_____ _____

Name Relationship

_____ _____

Name Relationship

X_____ _____ _____

Signature of Patient Date Witness

MADISON
DENTAL CARE

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs occurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within (5) days of billing if credit is extended. I further agree that the charges for services shall be billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

_____ I have read the above conditions of treatment and payment and agree to their consent.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Privacy Consent – HIPAA Notice

Madison Dental Care is required by applicable federal and state law to maintain privacy of your protected health information. We are also required to provide our patients NOTICE about our privacy practices, legal duties and your rights concerning your protected health information. Madison Dental Care will follow the privacy procedures that are described in this Notice while it is in effect. Prior to commencing your treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account, or health care operations.

You have the right to review our office's privacy notice prior to signing this CONSENT; a copy of this can be provided to you.

You have the right to request restrictions on the use of your health information; however, we are not required to, and may not, honor your request.

Madison Dental Care reserves the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Madison Dental Care reserves the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide a new Notice at our practice location, and we will distribute it upon request.

You may revoke this consent at any time in writing; however, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

Signature of Patient (or Parent/Guardian if Patient is a Minor):

_____

Print Name:

_____

Date:

_____

MADISON
DENTAL CARE

American Dental Association Guidelines for Premedication for Dental Visits

For most people, dental treatments are routine and require no pretreatment planning. However, some people have certain medical conditions that require them to be medicated with antibiotics before dental treatment is performed. Certain dental procedures require taking an antibiotic to prevent an infection. Bacteria that are always present in the mouth may settle in another part of the body during or after a dental procedure. Those patients at risk are generally those that have had artificial joints, heart valve damage, or are otherwise medically compromised. For patients that meet these criteria, premed is required for any visit that requires us to do more than just visually look. If you have any questions regarding our premed policy or any other matter, please feel free to contact our office.

Preventative antibiotics prior to a dental procedure are advised for patients with:

- Recent heart surgery within past six months
- Cardiac transplant that develops a heart valve problem
- Pacemaker
- Within six months of vascular surgery (artery replacement)
- Artificial heart valve
- History of rheumatic fever
- History of infective endocarditis
- Systemic pulmonary stunt
- Congenital heart defect
- Acquired valvular dysfunction
- A total joint replacement (premedication not necessary if you have received only pins, rods, mesh appliances)*

*The ADA guidelines are inconclusive regarding total joint replacement. It is our office policy to have our patients premed unless they obtain written permission from their MD stating premedication is not necessary.

Have you ever had any of the above listed procedures/conditions? If yes, which one?_____

_____

When was it diagnosed?_____

Signature: _____ Date: _____

MADISON
DENTAL CARE

Madison Dental Care Office Policies

- Madison Dental Care follows the American Dental Association protocol for x-rays. Bitewings are taken once every year depending on health and caries(cavities) risk. Full Mouth x-rays are taken every 3-5 years.
- At every hygiene visit we will assess the health of your gums. If they do not fall within the ADA guidelines for a healthy mouth cleaning, a regular cleaning will not be done.
- Madison Dental Care requires every patient to have their blood pressure taken at every visit. We do this in our patient's best interest. We do not want to lay a patient back with their blood pressure elevated, putting the patient at risk for a stroke.
- We require a 25% deposit of patient's copay on all appointments that are 2 hours or over
- We require our patients to confirm their appointments via text, email or phone. If it is not confirmed through email or text, we will make several attempts to call. After all attempts, if the appointment is not confirmed, we will take you off the schedule. We require a 24-hour notice for all cancellations and/or reschedules.
- There is a $50 fee for same-day cancellations.
- There is a $50 no show fee on all missed appointments.
- Patient is responsible for any balance that their insurance does not cover. The payment is due at the time of service.

Madison Dental Care

Understanding and Consent to Dental Treatment

Please review the following consent form. You are required to sign prior to any treatment, however it does not commit you to treatment.

Teeth are traumatized in many ways. They are regularly traumatized by chewing, clenching and grinding. Teeth wear as we age. They may become shorter and weaker, develop cracks, fractures or actually be lost. The bacterial decay process that invades teeth also can significantly traumatize and weaken teeth. Any of these traumas can lead to the need to restore or replace a tooth or several teeth. A tooth may need treatment as little as a simple filling or a full coverage crown (cap). It may need to be replaced with a bridge or a dental implant. A tooth that has to be restored will have to be prepared (drilled), medicated, filled or covered. If a laboratory constructed crown is indicated a temporary crown will be constructed and cemented in place while the final crown is being fabricated. Upon return the final crown is evaluated for fit, bite, contours and aesthetics, then inserted with a strong cement.

Due to close proximity with the nerve, any and all of the above procedures can traumatize the pulp (nerve) of a tooth leading to intermittent sensitivity to hot, cold and/ or chewing. The pulp may become irreversibly inflamed thus needing root canal therapy to remove the injured nerve. A tooth becomes fragile after the pulp is removed and a crown is indicated to protect it from breaking. A simple filling may result in the need for root canal treatment, a crown build-up and a crown. Most teeth survive well, but some need more treatment than initially anticipated.

X-rays and visual examination do not tell us everything. There may be unexpected decay or breakdown under and around an old restoration or a crack in a tooth may go deeper than first anticipated. If any change to the initial treatment plan occurs we will inform you immediately and advise you of your options.

We prepare teeth as conservatively as possible to minimize trauma. They are medicated and restored only with ADA and FDA approved chemicals, materials and devices. Methods and techniques used have been successful in dentistry for many years. We blend the newest technologies with proven methods to best serve our patients.

Your health plays a major role in success of treatment. It is your responsibility to advise us of all the medications you are taking, any changes in your medications or if you are allergic to any medication. Please inform us of any health conditions or any change in your health. You must inform us of any adverse reaction to any treatment rendered by us or in any past dental or medical office.

If there is anything that you do not understand about your proposed treatment, any statement in this form or if you have any questions about this form or about what the doctors or staff have discussed with you, please write your questions below and we will be happy to discuss them. If you have no questions or comments write "None, "then sign and date this form.

Thank you for allowing us to be your dental care providers.

Comments & questions

Understood & Agreed

_____ _____

Signature of patient/guardian Date